MEDICAL RECORDS RELEASE AUTHORIZATION

I hereby authorize:

____
Name of Physician or Facility

____
Address

______________________ ________ ________
City State Zip

To release the following:

[ ] My entire medical record

[ ] Labs/Pap: ______________________________

[ ] Other: ______________________________

To: **Conway Regional Renaissance Women's Center**
2300 Robinson Ave.
Conway, AR 72034
Phone: 501-548-6100
Fax: 501-548-6105

This authorization is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior authorization, except as provided by law
2. A photocopy or fax of this authorization is as valid as the original
3. I may revoke this authorization at any time, except when information has already been released
4. I understand that my treatment, payment, enrollment, or eligibility of benefits will not be conditioned on whether I sign this authorization
5. This authorization will remain in effect in until revoked by me in writing

______________________________ ______________________
Patient Name and Social Security Number Date of Birth

______________________________ ______________________
Patient Signature Date Signed